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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia

Note by the Secretariat

Pursuant to Human Rights Council resolution 33/9, the Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia, which took place from 28 November to 6 December 2016.

As the newest member of the European Union, Croatia has made progress regarding the realization of the right to health, in particular by strengthening primary and specialized health care and investing initial efforts in necessary reforms to mental health care. The Special Rapporteur encourages the Government to advance further by developing policies guided by a human rights-based approach, in line with the 2030 Agenda for Sustainable Development (General Assembly resolution 70/1), avoiding retrogressive measures and paying particular attention to groups in the most vulnerable situations, including women, children, people on the move, national minorities, persons with intellectual, cognitive and psychosocial disabilities and older persons. The report addresses challenges and opportunities and makes a number of recommendations recalling the need to use financial resources in a transparent manner and in full compliance with international human rights.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia*

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* Circulated in the language of submission only

I. Introduction

1. The Special Rapporteur visited Croatia from 28 November to 6 December 2016 at the invitation of the Government. The purpose of the mission was to ascertain, in a spirit of cooperation and dialogue, national endeavours to implement the right to health, measures taken for its successful realization, and the obstacles encountered.

2. The Special Rapporteur met with high-ranking government officials from the Ministries of Foreign and European Affairs; Health; Demographics, Family, Youth and Social Policy; Finance; Science and Education; and Labour and the Pension System, and from the Offices for Gender Equality, Human Rights and Rights of National Minorities and the Office of the Agent of the Republic of Croatia before the European Court of Human Rights. He also met with members of the parliament and the Constitutional Court, as well as with the Ombudswomen and the Ombudspersons for children, persons with disabilities and for Gender Equality. In addition, meetings were held with representatives of civil society, international organizations and United Nations entities.

3. The Special Rapporteur visited health facilities, a secondary school and a community-based facility for persons with psychosocial disabilities, a reception centre for asylum seekers, a Roma settlement and a drug dependence centre, in Zagreb, Osijek, Vukovar and Split.

4. The Special Rapporteur is grateful to the Government of Croatia for its invitation and outstanding cooperation prior to and during the visit. He appreciates the important support provided by the United Nations in the country, including the United Nations Development Programme, the World Health Organization (WHO), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Children's Emergency Fund and the International Organization for Migrants.

II. Framework of the right to health in Croatia

A. Background

5. After attaining independence from the Socialist Federal Republic of Yugoslavia in 1991, Croatia successfully joined the European Union in July 2013. The process involved the overall revision of, and amendments to, approximately 680 pieces of legislation, which inter alia brought improvements in terms of the human rights framework, including a strengthened role of the Ombudsperson.

6. In the health-care sector, accessing the European Union required the normative and institutional framework to be harmonized and relevant European Union regional strategies (i.e., the European Commission health strategy) became immediately applicable.[1]

7. The current health-care system maintains the pre-1991 principles of universality and solidarity with elements from the various reforms that the sector has undergone owing to, inter alia, the process of independence and the global financial crisis of 2008. Thus, one public entity, the Croatian Institute for Health Insurance, has now consolidated previously separate insurance schemes (for employees, farmers and artisans and the self-employed), absorbing most of the health-care budget. Some private providers are also active in certain areas.

8. The share of the gross domestic product (GDP) allocated to the health sector has gradually increased since the 2000s, reaching 6.7 per cent of GDP in 2015; however, it has

[1] See European Observatory on Health Systems and Policies, "Croatia: Health system review", *Health Systems in Transition*, vol. 16, No. 3 (2014), p. 21. Available from www.euro.who.int/__data/assets/pdf_file/0020/252533/HiT-Croatia.pdf?ua=1.

not yet reached the levels of most European Union countries (on average 9.5 per cent).[2] Within the health sector alone, the proportion of public expenditure decreased between 1995 and 2012, but continues to be high compared with most countries in the European Union,[3] showing the continued priority of the sector on the national agenda.

9. Croatia made good progress with regard to all indicators linked to child mortality (Millennium Development Goal 4), under-5 mortality rate notably decreased from 12.8 deaths per 1,000 in 1990 to 4.5 per 1,000 in 2013. Advances have also been reported for some indicators linked to maternal health (Millennium Development Goal 5), in particularly the maternal mortality rate, which decreased from 10 per 1,000 in 1990 to 8 per 1,000 in 2015. The Special Rapporteur regrets, however, that information on other indicators for Millennium Development Goal 5 is not available, notably regarding contraceptive prevalence rates and unmet needs for family planning. Progress has also been achieved on indicators linked to Millennium Development Goal 6, in terms of tuberculosis incidence, prevalence, death rate per year, detection and treatment.[4]

10. Future endeavours should involve investment in rights-based approach policies, in line with the Sustainable Development Goals. Croatia should use the historic opportunity presented by becoming a European Union member and the global adoption of the 2030 Agenda to further advance the right to health. Additional progress could be achieved on issues related to the Millennium Development Goals that remained underreported and are now linked to the new global goal, Sustainable Development Goal 3.7 on universal access to sexual and reproductive health-care services. Action in this regard will be strengthened by the effective implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). Further issues related to the Millennium Development Goals that could still be advanced relate to certain universal health coverage indicators (Sustainable Development Goal 3.8) and to mental health (Sustainable Development Goal 3.4).

11. European Union structural funds should be devoted to developing rights-based health-care policies and services and should be used in a transparent manner in full compliance with universal human rights principles.

B. Normative and institutional framework

12. Croatia has ratified most of the international human rights treaties.[5] Between 2014 and 2015, it underwent reviews by the Human Rights Committee, the Committee on the Elimination of Discrimination against Women, the Committee on the Rights of the Child and the Committee against Torture). While Croatia has been a party to the Covenant on Economic, Social and Cultural Rights since 1992, its second periodic report to the Committee is currently overdue. In October 2016, Croatia was elected a member of the Human Rights Council for 2017 to 2019, with the possibility of re-election for a second consecutive term.

13. In 2003, Croatia extended a standing invitation to the special procedures of the Human Rights Council, and the Special Rapporteur on the right to health is the fifth mandate holder to visit the country since then. Croatia underwent the universal periodic review process in 2013 and 2015 and the country's next review is scheduled for May 2020.

14. At the regional level, Croatia is a party to the European Convention on Human Rights, the European Social Charter and its Additional Protocol and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or

[2] Ibid., pp. 51-59, and European Commission, "Country report Croatia 2017", p. 53. Available from https://ec.europa.eu/info/file/96682/download_en?token=k-4wwF_K.

[3] In 2013, 17.6 per cent of the total State budget was allocated to health care: see European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 51-59.

[4] Millennium Development Goal data. Available from http://mdgs.un.org/unsd/mdg/Data.aspx.

[5] With the exception of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and pending ratification of the Convention for the Protection of All Persons from Enforced Disappearance, signed on 6 February 2007.

Punishment. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has visited the country on four occasions, most recently in 2012, and has issued recommendations regarding the right to health, notably in relation to health care in prisons and in psychiatric institutions. The European Court of Human Rights has also dealt with cases regarding, inter alia, inhuman or degrading treatment towards persons with psychosocial disabilities and adequate or inadequate support for, or the deprivation of, legal capacity of persons with intellectual, cognitive or psychosocial disability resulting in human rights violations.[6]

15. Nationally, the right to health has been enshrined in the Constitution (current art. 59) since its promulgation in 1990, together with relevant rights, including informed consent (art. 23), rights to life (art. 21), to suitable life (current art. 63), healthy life (current art. 70) and the rights to equality and non-discrimination (arts. 1, 3, 14, 15 and 17). Pursuant to current article 59 "everyone shall be guaranteed the right to health care in conformity with the law".[7]

16. The most important legal acts governing the right to health are the Health Care Act (2008) and the Mandatory Health Insurance Act (2013).[8] The former regulates the organization and provision of health care, rights and obligations of users and the responsibilities of health-care institutions at different levels; establishing the principles for their monitoring. The Mental Health Insurance Act is explained below.

17. Specific areas are regulated in other acts, including the Patients' Rights Protection Act, the Medical Practice Act, the Pharmacy Act, the Nursing Act and the Dental Care Act; the Midwifery Act; the Physical Therapy Activities Act, and the Act on the Health Care Technical Services. The quality of health-care services is regulated in the Act on Quality of Health and Social Care and the provision of voluntary health insurance is governed by the Voluntary Health Insurance Act.

18. The national human rights institution is the Office of the Croatian People's Ombudsman. It was established in 1992 and over the years has progressively been assigned additional responsibilities. At present, it functions as a national human rights institution, central equality body and national preventive mechanism.[9] In 2008 and 2013, the Ombudsman was accredited "A" status by the Sub-Committee on Accreditation of the then International Coordinating Committee,[10] in compliance with the principles relating to the status of national institutions for the promotion and protection of human rights (Paris Principles). The Office, under the Ombudsman Act of 2012, examines human rights complaints and submits annual reports to the parliament.

19. Complaints currently dealt with by the Ombudsperson come under 17 discriminatory grounds as listed in the Anti-discrimination Act (art. 1, (1)),[11] exempting gender, gender identity and expression and sexual orientation; discrimination against children; and disabilities, as these are dealt with by specialized ombudspersons for gender equality and for children (both introduced in 2003) and for persons with disabilities (established in 2008), respectively.

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[6] See European Court of Human Rights, press country profile: Croatia. Available from www.echr.coe.int/documents/cp_croatia_eng.pdf.

[7] See Constitution of the Republic of Croatia 2010 (consolidated text), Zagreb, 6 July 2010. Available from www.sabor.hr/fgs.axd?id=17074.

[8] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 15 and 17-18.

[9] See European Network of Equality Bodies, brief profile, Office of the Ombudsman — Croatia. Available from http://adsdatabase.ohchr.org/IssueLibrary/Office%20of%20the%20Ombudsman%20-%20Croatia.pdf.

[10] In 2016, the International Coordinating Committee changed its name to the Global Alliance of National Human Rights Institutions. See national human rights institutions accreditation status chart at www.ohchr.org/Documents/Countries/NHRI/Chart_Status_NIs.pdf.

[11] Anti-discrimination Act, July 2008. Available from www.minoritycentre.org/sites/default/files/antidiscrimination_law_croatia.pdf.

20. Since 2011, the Government has been obliged to monitor and report on the fulfilment of recommendations issued by the Ombudsperson.[12]

C. The national health-care system[13]

21. With a population of about 4.3 million, life expectancy at birth in Croatia (81 years in 2014) has progressively increased; although it remains slightly below the European Union average (83.6 years).[14] As in many European countries, the population in Croatia is ageing, requiring adjustments in the health-care system. Furthermore, new public health concerns have emerged, including overweight and obesity, together with concerning trends in low levels of physical activity, for which rates continue to decrease. More than half of men and women are overweight and one fifth of the population is obese.[15]

22. While alcohol consumption, smoking and unhealthy diet show some positive trends,[16] official information shows that drug dependence has steadily increased,[17] and public mental health continues to be an area requiring attention. In 2015, mental and behavioural conditions were one of the most common reasons for users to seek hospital treatment.[18]

The sector in transition

23. Since the process of independence, the health-care sector has faced financial difficulties which have been tackled since the 1990s with various austerity measures. Between 2008 and 2011, health-care reforms aimed at financial stability were undertaken but neither underwent proper consultation with the main stakeholders, nor were always combined with thorough implementation plans and thus resulted in partial implementation.[19] Subsequent reforms have been focused on achieving cost-effectiveness in the hospital sector.

24. According to the European Commission,[20] arrears in the health sector in combination with inadequate administrative capacity and strategic planning have hindered the absorption of European Union funds. Health-related current arrears are largely linked to the organization and structure of hospitals, which are concentrated in metropolitan areas and mainly managed through a funding and reimbursement model, on the basis of advance payments. In addition to the hospital reforms needed, the European Commission has stressed the need to reduce pharmaceutical expenditure and draw up concrete plans to address accumulation of arrears.

25. In 2015, public consultations to reform the Health Care and Mental Health Insurance Acts to introduce cost-reduction measures triggered a debate about their impact on the quality of health-care services, which could be diminished, disproportionately affecting people in the most vulnerable situations. Additional issues raised included the potential disparities that could result from medical doctors working simultaneously in the public and

[12] See universal periodic review of Croatia, national human rights institution joint coalition report, 2nd cycle, September 2014. Available from www.ohchr.org/Documents/Issues/OlderPersons/NGOAA/NHRI_Croatia.docx.

[13] See European Observatory on Health Systems and Policies, "Croatia: Health system review".

[14] See Eurostat, Statistics explained, File: Life expectancy at birth, 1980-2014 (years). Available from http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980%E2%80%932014_(years)_YB16.png.

[15] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 10.

[16] Ibid., pp. 10-13.

[17] See Office for Combating Narcotic Drug Abuse, "National strategy on combating drug abuse in the Republic of Croatia for the period 2012-2017, p. 7. Available from www.emcdda.europa.eu/system/files/HR_National%20strategy_en.pdf.

[18] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015* (Zagreb, 2016), p. 21. Available from www.hzjz.hr/wp-content/uploads/2017/02/Ljetopis_2015_IX.pdf.

[19] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 123-129.

[20] European Commission, "Country report Croatia 2017", p. 54.

private sectors. Owing to lack of compliance of the consultations process with the Regulatory Impact Assessment Act and the Act on the Right to Access to Information, the 2015 reform was partly interrupted.[21]

26. The Special Rapporteur recalls that any reform in the health-care system should include the meaningful participation of all major stakeholders in policy decision-making, as well as independent monitoring and review of outcomes and be based on population health status indicators and the performance of the health system. Implementation of the principles of accountability, participation and transparency allows health-care systems to be self-critical and prevents the ineffective use of resources and corruption within the system.

Universal coverage and affordability

27. The Ministry of Health is the main authority responsible for health policy, planning and evaluation; public health programmes, and the regulation of investments. Health-care services in Croatia are organized as a network of public health institutes with one national institute, managed by the Ministry of Health, and 21 in each county, managed by the counties. The national institute coordinates and supervises national institutions and is responsible for gathering, analysing and publishing statistics. Counties develop local plans, collect local statistics and participate in the formulation and implementation of local plans.

28. Health-care institutions (university hospitals, national institutes and specialist clinical hospitals) may only be established by the Ministry of Health. Four university hospital centres, in Zagreb, Split, Rijeka and Osijek, provide training and education for future medical doctors and conduct scientific research. Other facilities, including general and specialized hospitals; primary health centres; county institutes of emergency medicine and public health; outpatient clinics; spas; facilities providing home and palliative care; and pharmacies, may be established by each county.

29. Long-term health care in Croatia mainly concerns older persons and persons with intellectual, cognitive or psychosocial disabilities and is mostly organized through the social welfare system and provided in institutional settings. Since 2013, the Social Welfare Act has sought to progressively withdraw institutional long-term care for older persons by keeping them at home with their family; promoting their social inclusion and improving their quality of life through non-institutional services and volunteering.

30. Through the Mandatory Health Insurance Act all Croatian citizens and residents have the right to health. The single insurer in this scheme is the Croatian Institute for Health Insurance, established in 1993 to provide universal health insurance coverage to the whole population, based on a benefits package defined under the Mental Health Insurance Act scheme. Basic health-care services are provided according to users' needs.

31. The Croatian Institute for Health Insurance has an important role in defining basic health services, performance standards and the prices of services covered under the Mental Health Insurance Act scheme. It is also responsible for relevant social security allowances and benefits, including sick leave compensation and maternity-related benefits, and is the main provider of supplemental health insurance.

32. In 2013, most of the Government's health-care budget (91 per cent) was allocated to the Croatian Institute for Health Insurance, which is also funded by contributions from employees, the self-employed and farmers. Full contributions are paid by only about a third of the population and certain groups are completely exempt, including those under 18 years of age, students, the military, war invalids, unemployed persons, persons with disabilities and blood donors upon reaching a predetermined donation amount. These groups are financed from the payroll of contributing users and from transfers by both government and county budgets. Contributions represent 76 per cent of the Institute's total income.

[21] See "Annual report of the Ombudswoman of the Republic of Croatia" (31 March 2016), p. 78. Available from http://ombudsman.hr/attachments/article/1016/Annual%20Report%20of%20the%20Ombudswoman%20of%20Croatia%20for%202015.pdf.

33. Some health-care services under the Mental Health Insurance Act are subject to co-payments and the relevant amounts are defined according to the users' ability to pay. In addition, supplemental health insurance is available and is purchased individually and on a voluntary basis, from either the Croatian Institute for Health Insurance or private insurers, mostly to cover user charges in the Mental Health Insurance Act system. Persons with disabilities, human organ and blood donors, students and low-income persons have the right to free supplemental health insurance from the Institute.

34. In Croatia, the right to affordable health care has been impacted since 2003, with increases in co-payments for practically all services and the introduction of service rationing. However, groups in vulnerable situations have been financially protected through full coverage and free supplemental health insurance. In addition, co-payments, usually paid through the supplemental insurance, cannot exceed a fixed limit.

Access to health-care services

35. Users' regular first point of contact with the health-care system is the general practitioner at the primary care level. Users may choose their own general practitioners and dentists, as well as gynaecologists and paediatricians, as applicable. All of them are categorized as general practitioners in Croatia. There must be at least one primary health-care centre in each county and three in Zagreb. Users may also choose their specialist and hospital, and are not restricted to their place of residence in this.

36. As noted by WHO[22] and observed by the Special Rapporteur during the visit, there is a tendency to skip the primary level to search for specialized care, under an overall misconception that primary care may not provide the necessary attention and quality of care. The Special Rapporteur stresses that primary health care is the cornerstone and the means of sustainability of any health-care system, which functions more effectively and rationally when the majority of cases (up to 80 per cent) are dealt with at the primary level. This allows for the accumulation of resources to finance expensive treatments for severe and complex medical cases at the specialist level.

37. Solid primary health-care services which are trusted by the people are crucial in rationalizing the resources allocated to specialist medicine and to costly inpatient health care. A number of studies show that health systems can improve equity, efficiency, effectiveness and responsiveness by strengthening primary care while decreasing the unnecessary use of specialists and hospital care.[23]

38. Croatia needs to strengthen primary health care, both in quantity and quality, for the early detection and treatment of mild forms of illnesses, before they reach the stage at which they require specialist care. An optimal balance between general practitioners and specialists should be sought by providing outpatient specialist care which backs up the general practitioners. Specialists should receive patients referred from general practitioners and consult with them on the cases, notably regarding treatment for non-complicated cases. Otherwise, specialist care risks saturation. Where physical health is concerned, the majority of health conditions are mild cases that should be managed by general practitioners.

39. To achieve a balance between general practitioners and specialists, the capacities and competencies of general practitioners and their teams (nurses, social workers and assistants) should be improved, through continuous learning programmes and incentives to consolidate their position as "gatekeepers" of the system.

40. As noted by the European Commission, strengthening primary health care in Croatia would bring about reductions, not only in the number of referrals to specialists, but in the cost of specialist and hospital treatments. The Commission has stressed the over-reliance on hospital services, due to the partial development of primary care in Croatia, recommending a reorganization of the current unequal distribution of hospitals to promote fiscally

[22] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 97.

[23] See M. Seychell and B. Hackbart "The European Union Health Strategy — Investing in Health", *Health Reviews*, vol. 35, No. 1, p. 7.

responsible hospital management and gain sustainability.[24] WHO has further noted the lack of care pathways for users which would help to change the practice of skipping the primary level to look for a specialist.[25]

Challenges with regard to access to health care and informed consent

41. While unmet needs for medical examination in Croatia are below the European Union average, inequalities in accessing health care have increased since 2012, notably due to distance-related challenges linked to the country's geography and large number of islands (over 1,000). During his visit, the Special Rapporteur was briefed about the unequal access to health care faced in particular by older persons, children and pregnant women in rural areas, smaller towns and islands with poor traffic connections to large cities. He was also briefed about promising initiatives to address challenges with a strategic framework for islands that would improve connections by the use of speed boats, in addition to helicopters, for medical doctors in large cities, to increase the frequency of consultations in remote locations. He trusts that these initiatives will be implemented.

42. Health-care complaints dealt with by the Ombudsperson increased from 64 in 2012 to 178 in 2015.[26] Complaints in 2015 included issues linked to accessing certain health-care services such as therapies for rare diseases, problems in making doctor's or treatment appointments, long waiting lists and the overall quality of health-care services, treatments and facilities.[27]

43. During the visit, the Special Rapporteur was consistently informed that the most pressing challenges to access to the right to health in Croatia were the long waiting lists for medical procedures and the limited access to good quality medical treatments. Both issues seem ultimately to compel users who can afford it to turn to private providers, although, generally speaking, the same doctors are employed simultaneously in both the public and private sectors. Private services seem to allocate more time for users and to provide more information on treatments, their effects and options, giving rise to discrimination against users who cannot afford private services and/or are less educated and do not get adequate information on their health and treatments owing to the lack of time allocated in public services to provide information about them.

44. The issue of long waiting lists was partially dealt with in 2015 through some programmes for specific medical procedures, which were successful in certain cases.[28] However, the overall issue of long waiting lists seems to be far from being sufficiently addressed, as illustrated by cases of rehabilitation treatment linked to surgery which can take several years to be approved and actually provided.

45. Lastly, while the rights to be informed on alternative treatments and to consent to or refuse treatment are protected by the national framework,[29] the Special Rapporteur ascertained that informed consent seems not to be well understood by health-care personnel. In practice, informed consent has become a simple formality, whereby users are often requested to sign the relevant consent form in the waiting room before meeting the doctor. In addition, it was reported that three out of five women in Croatia do not participate meaningfully in decisions concerning labour and birth.

46. To address these issues appropriately, official statistics on waiting lists and proper assurances of users' consent should be produced, and result-assessments of 2015 programmes should be conducted. All measures aimed at addressing the issues should take account not only of accessibility and availability, but also of the quality of services.

[24] See European Commission, "Country report Croatia 2017", p. 54.
[25] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 97.
[26] See "Annual report of the Ombudswoman" (2016), p. 8.
[27] Ibid., p. 126.
[28] Ibid., p. 125.
[29] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 45.

III. Health care in institutions and the way forward

A. Mental health framework

47. At the international level, mental health is increasingly taking priority, as reflected by recent discussions at the Human Rights Council[9] and at WHO headquarters, where the issue has recently been addressed as a priority. The Committee on the Rights of Persons with Disabilities has raised the issue of the need to fully guarantee the exercise of all human rights, including the right to health, to persons with disabilities and especially those with intellectual, cognitive and psychosocial disabilities.

48. Croatia was among the first countries to ratify the Convention on the Rights of Persons with Disabilities in August 2007 and, during the visit, the Special Rapporteur was encouraged at the new legal framework and measures aimed at addressing many of the recommendations of the Committee on the Rights of Persons with Disabilities. In 2012, in amendments to the electoral law, the right to vote was granted to 18,000 people with intellectual, cognitive or psychosocial disabilities who had been deprived of their legal capacity for decades. Further steps include reforms to the Social Welfare Act with regard to deinstitutionalization, as explained in the following section and the new Family Act which, inter alia, abolishes full guardianship and establishes a five-year deadline for reviews of all court decisions on deprivation of legal capacity, combining the concepts of mental and legal capacity and introducing the concept of supported decision-making.

49. The Law on the Protection of Persons with Mental Disorders (2015), which replaces an earlier law on mental health, now provides for stronger mechanisms and guarantees to progressively reduce involuntary institutionalization, including the requirement, under judicial control, for the written consent of a legal guardian or trusted person in the case of non-consensual hospitalization of persons with intellectual, cognitive and psychosocial disabilities "unable" to give consent. The law also introduces the possibility of independent supervision over the decisions of legal guardians.

50. The Ministry of Health is the body primarily responsible for mental health care through national strategies. The strategic plan for the development of public health includes the goals of the promotion of mental health, prevention, social inclusion and rights protection. Other policies with elements of mental health include deinstitutionalization plans in the social welfare system and provisions to include mental health themes at preschool and primary and secondary school levels.

51. While mental health care is provided in Croatia at the primary level (general practitioners, school medical specialists, psychiatrists and professionals in mental health centres and public health institutes), the secondary level (mental health professionals, mainly psychiatrists) and the tertiary level, the mental health system is still too focused on psychiatric hospitals. Since 1991, inadequate attention has been paid to the development of outpatient mental health services at the community level, which has led to an overreliance of the system on inpatient services, mainly provided at psychiatric hospitals. To illustrate, mental health conditions are one of the most common reasons for hospital treatment and nearly one in four days of hospital treatment is used to treat a mental condition.[10]

B. Deinstitutionalization

52. Deinstitutionalization has been a key policy priority for the Government for some years, but mainly within the social welfare sector, with low participation by the health sector. In 2011, the Ministry of Demographics, Family, Youth and Social Policy formulated the National Plan for Deinstitutionalization and Transformation of Social Welfare Homes

[9] In its resolution 32/18, the Human Rights Council requested the United Nations High Commissioner for Human Rights to prepare a report on mental health and human rights. The report (A/HRC/34/32) was submitted to the Council at its thirty-fourth session.

[10] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015*, p. 22.

2011-2018. Two years later, several institutions began the process of finding homes for persons previously institutionalized. In 2014, the Plan was revised to, inter alia, integrate and operationalize funds from the European Union. The Plan is aimed at, inter alia, transforming former homes into community services, developing community support and integrating users into the community.

53. The Special Rapporteur learned that, by 2016, through deinstitutionalization, approximately 600 persons had been moved out of institutions to community-based services. However, he also learned that the same number of people have since been institutionalized in hospitals through the health-care system. While commendable efforts by the social welfare system are directed at reducing reliance on institutional care, stigma and discrimination by decreasing the number of people living in institutions, the health-care system, largely based on treatment in psychiatric hospitals with mainly biomedical interventions, continues to "feed" the institutional care system. This shows the lack of an effective "gatekeeping" policy in the health-care sector and, above all, the urgent need for coordination between the social welfare and health sectors.

54. The capacity in psychiatric institutions continues to escalate, as shown by the increasing number of psychiatric beds[17] and the increasing amount of financial resources directed at enhancing hospital infrastructure, a situation that was observed by the Special Rapporteur in his visit to a psychiatric hospital in Zagreb which was in the process of expanding, with the construction of a new building for forensic patients.

55. On the other hand, Croatia is one of the first countries to have invested in community-based pilot projects to end institutionalization. One good practice is the work carried out at the "I am just like you" Centre in Osijek. The Special Rapporteur visited the Centre and was pleased to confirm the full inclusion of people with psychosocial disabilities in society, living in ordinary apartments, in small groups, with minimal regular support from Centre staff. The Special Rapporteur strongly recommends that this good practice be replicated elsewhere in Croatia and in other countries. This experience shows that transforming institution-based services into community-based services is beneficial for persons with psychosocial disabilities and for society at large. It also shows that, where there is a will, it is possible to end the sad legacy of institutional care.

56. Successful pilot projects to integrate persons with psychosocial disabilities into the community, such as that in Osijek, have not been taken seriously as making a real difference in the Croatian mental health system, its funding or decision-making, which remain focused on large inpatient and residential psychiatric institutions. The Ombudsperson for persons with disabilities has consistently stressed the need to reorganize mental health services and to move away from the model of recurrent hospitalization towards more outpatient support and treatment and community-based services.

57. The Special Rapporteur was informed that approximately 4,200 people with intellectual, cognitive and psychosocial disabilities still live in institutional care, deprived of their liberty and unable to fully enjoy their rights on equal terms with other members of society. Of those, persons with psychosocial disabilities are the largest group institutionalized in Croatia.

58. Croatia should develop policies strongly oriented towards addressing the needs and rights of service users, as opposed to the needs of the existing service infrastructure. In this respect, Croatia could use the unique opportunity represented by the availability of European structural support funds to continue transforming the mental health-care system in an enhanced manner. Any health-care reform demands additional resources owing to the time needed for the new system to be operational. There will be a period when the old ineffective system and the rights-compliant reformed system should be running simultaneously, as it is not possible to implement a radical programme of closures of residential institutions and psychiatric hospitals before alternative services are well developed and integrated into primary care, community care and general hospitals.

[17] See European Observatory on Health Systems and Policies, "Croatia: Health system review", pp. 93-94.

59. European Union structural funds should be directed at building up a modern rights-compliant system throughout Croatia, with services that prevent referrals both to psychiatric hospitals and to large residential institutions. Rights-compliant and cost-effective mental health-care systems require the relevant services to be integrated into community-based health and social services.[77] Segregated institutions and large psychiatric hospitals for long-term health care should no longer be supported or expanded in Croatia. Instead, rights-compliant services should be developed at the community level, based on a combination of necessary psychotropic medications, psychosocial rehabilitation, psychotherapy, professional and vocational rehabilitation and supported housing.

60. While this shift in policy and practice is yet to be fully implemented, the country has invested considerable efforts into this enterprise. Croatia has an exceptional opportunity to replicate throughout the country the laudable undertakings that have proven to be rights-compliant and effective. Each county in Croatia should develop a health and social care plan to implement the transformation towards outpatient primary mental health care and community-based services, so that there is no longer a need to rely on large psychiatric institutions.

61. The country's ambitious plan to become an inclusive society, as the Special Rapporteur was informed during his visit, should fully incorporate mental health reform that fully integrates people with intellectual, cognitive and psychosocial disabilities and older persons into society.

IV. Sexual and reproductive health rights

62. Progress on the right to health of women in Croatia includes advances in certain health indicators such as maternal mortality. A welcome development before the Special Rapporteur's visit was the announcement of the intention of Croatia to ratify the Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention), which Croatia had signed in January 2013. He trusts that ratification will soon take place.

63. Various challenges to women's realization of their right to health remain insufficiently addressed. The Special Rapporteur was able to observe that the concerns of the Committee on the Elimination of Discrimination against Women (see CEDAW/C/HRV/CO/4-5) remain valid to date and have, furthermore, been exacerbated by attempts to implement retrogressive measures, including the redefinition of marriage in the Constitution, which may limit women's right to access health care on the basis of their marital status, and a pending revision of the 1978 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth.

A. Maternal health care and women's rights during childbirth

64. Since 2010, Croatia has centralized birth and postpartum care in 31 maternity hospitals, closing down small maternity units which were reportedly working well. As a result, the distance between place of residence and maternity hospitals has increased, disproportionately affecting women on islands and in remote locations. Reports indicate that 52 per cent of women of childbearing age live outside cities with maternity hospitals and, in 2014, 2 per cent of births took place with the assistance of emergency teams on the way to hospital. However, there is a lack of more detailed official statistics on women living more than 30 km or 50 km from a maternity hospital and their access to health-care services.

65. As home birth is not regulated in Croatia,[78] the great majority of births take place in hospitals, attended by doctors with the assistance of midwives. Neither doctors nor

[77] WHO, "The World health report 2001 — Mental health: new understanding, new hope".

[78] European Parliament, "Petition No 1400/2014 by D. D. (Croatian) on an alleged breach of provisions on professional qualifications of midwifes of Directive 2005/36/EC in Croatia" (29 June 2016).

midwives may attend home births, except for accidental or emergency cases. This limits women's choice as to where to give birth. Consideration should be given to planned out-of-hospital births as an affordable and accessible option available to women so that they can make informed choices as to their delivery preferences. Women should not be deprived of medical assistance should they choose to give birth at home, and health-care personnel should be allowed to provide such assistance.

66. The Special Rapporteur was briefed about certain practices during labour and birth, very often employed without women's consent, sometimes even against their wishes, which in most cases remain undocumented. These include mandatory adoption of the supine position during the entire process of labour and birth, labours augmented with artificial oxytocin, routine enemas before giving birth, the extensive use of episiotomy; and the Kristeller manoeuvre: full-body pressure on the abdomen to attempt to speed up the delivery, sometimes associated with broken ribs, among other undesirable side effects. Women's privacy is not fully guaranteed, as hospital birthing rooms rarely have doors and, where they have, they tend to remain open.

67. With regard to medically assisted reproduction, while a new act of 2012 brought about improvements, the procedure is only available to heterosexual women and couples, while same-sex couples are explicitly excluded under the Law; single women may only have access to the procedure with proof of infertility, which is difficult to obtain in practice; and women aged 42 years and over can access private procedures only. Women who cannot afford the related costs are also left behind as only certain treatments are reimbursed by the Croatian Institute for Health Insurance and additional payments are required for the public notary, who must certify the relevant informed consent form. Medically assisted reproduction is reportedly the only health-care treatment in Croatia for which the consent form is not signed in a health-care facility.

68. The lack of official data regarding these issues hampers adequate assessment and the identification of appropriate measures.

B. Access to modern and emergency contraception

69. The use, availability and accessibility of modern contraception and reproductive services remain at a low level in Croatia and are excluded from coverage by the Croatian Institute for Health Insurance. In addition, updated data available on the area are insufficient. This hinders access and fosters misperceptions and lack of knowledge about these methods. Additional barriers relate to the relatively high price and inadequate availability of different types of contraceptives in the country.

70. Regarding emergency contraception, the Ombudsperson for Gender Equality has noted [9] that women who wish to purchase the brand authorized by the European Commission for sale without prescription are requested to answer a questionnaire, disclosing private information about their sexual behaviour and reproductive health which should be protected under their right to privacy (see Human Rights Committee, general comment No. 28 on equality of rights between men and women, para. 20). In Croatia, pharmacists can refuse to sell the contraceptive pill if they consider the answers to be unsatisfactory and must report the transaction to the woman's gynaecologist. Girls under 18 years of age are not allowed to buy the pill without third-party authorization by way of the required presence of a parent or legal guardian.

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[9] Available from www.europarl.europa.eu/RegData/etudes/STUD/2016/556931/IPOL_STU(2016)556931_EN.pdf.

[10] See European Commission, European network of legal experts in gender equality and non-discrimination, Country report – Gender Equality: Croatia 2010, p. 42. Available from www.equalitylaw.eu/downloads/556-2010-hr-country-report-gender.

C. The right to safe abortion

71. The 1978 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth establishes legal access to abortion for women up to the tenth week of pregnancy and with the approval of a commission for more advanced pregnancies in the following three cases: (a) pregnancy resulting from a crime, (b) to prevent damage to the woman's health or to save her life, and (c) serious congenital impairment of the fetus.[16] The Act also establishes that girls under the age of 16 require the consent of a parent or legal guardian, although, in practice, parental consent is reportedly requested for girls under 18 years of age.

72. In addition to the issue of third-party authorization, for some years the implementation of the Act has encountered various challenges, including its increasing cost, which is borne by the Croatian Institute for Health Insurance only in cases where abortion is necessary for medical reasons.[17] The Special Rapporteur was informed that the cost of abortion in five hospitals is above the country's net minimum salary per month.

73. In practice, access to safe abortion has been obstructed by the overuse of the legal provisions to deny it on the grounds of conscientious objection. Individual doctors are legally allowed to refuse diagnosis, treatment and rehabilitation on the basis of personal ethical, religious or moral beliefs and are required to promptly inform the user and make a referral to another appropriate medical professional.[18] The Special Rapporteur was further informed that while half of gynaecologists refuse to provide legal abortion in public hospitals on conscientious grounds, many of them offer the same service in their private practices in exchange for a fee. This calls into question the real grounds for the denial of abortion in public hospitals. Moreover, while legally only individual refusals are allowed, in practice refusals are exercised at the institutional level and, in some cases, as part of a hospital's policy.

74. Barriers to accessing public safe legal abortion services lead women to seek clandestine options, which put their integrity and health at risk and disproportionately affect women in situations of social exclusion and in remote areas who cannot afford or access other services. Failure to implement the law should be combined with appropriate sanctions and mechanisms to monitor its implementation. At present, there is no official data on the prevalence of conscience-based refusals, which prevents the development of effective measures to address these challenges.

75. The Special Rapporteur is concerned about announcements in October 2016 on the assessment and possible repeal of the Act on Abortion of 1978. Any legal measures that restrict existing core provisions in the protection of human rights constitute retrogressive measures in contravention of the relevant international framework.

D. Sexuality education

76. While sexuality education was introduced as part of the curriculum for health education in elementary and secondary schools, only two hours per year were allocated to the subject. Moreover, the delivery of the relevant module depends on the teacher concerned, as ascertained by the Special Rapporteur during his visit to a secondary school. Teachers often refuse to deliver sexuality education on the basis of arguments that are contrary to universal human rights that prevent children and adolescents from learning about gender equality and from making informed decisions about their bodies and sexuality, including about healthy sexual behaviours and the use of contraceptives.

[16] Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth, Act No. 1252-1978 of 21 April 1978, art. 22.

[17] See European network of legal experts in gender quality and non-discrimination, *Country report — Gender Equality: Croatia 2016*, p. 42.

[18] Conscientious objections may be exercised by doctors as long as the doctor's refusal does not conflict with the rules of the medical profession and does not cause permanent damage to the user's health or life (see Medical Practice Act, art. 20).

Adolescent students who met with the Special Rapporteur expressed their need for more and better age-sensitive comprehensive sexuality education.

77. The Ombudsperson for Children has further noted the overall absence of systematic health education, such as education on sexually transmitted diseases, including HIV/AIDS, which should be provided through an increased number of lessons delivered by competent experts. Overall, teachers should be trained on health and sexuality education to enable them to deliver quality information to students, with the use of good quality teaching materials.

E. Other challenges

78. Remaining challenges in Croatia regarding women's right to heath include issues at work, assistance to victims of domestic violence and the current sociopolitical environment vis-à-vis women's rights.

79. While the Labour Act prohibits employers from asking questions about women's pregnancy plans and from denying, terminating or reassigning employment on account of pregnancy, available data indicate that many women have been asked at job interviews about their plans to have children; overlooked for promotion on account of being mothers; have not had their contracts extended owing to pregnancy or other parental obligations or have been discriminated against at some point in their careers or job searches on account of their parental obligations.

80. Additionally, maternity benefits are subject to employment status, putting women who are on part-time contracts at a disadvantage. After sick leave linked to pregnancy, maternity leave or parental leave, women on part-time contracts are considered to be unemployed and receive lower maternity or parental benefits, despite having worked before their maternity leave.

81. The Ombudsperson for Gender Equality has warned that women's participation in the workplace is undermined by the lack of adequate day care for preschool and school-age children. Costs, which vary considerably by region and parents' income, are another significant barrier.

82. Notwithstanding the remaining challenges, the Special Rapporteur was also apprised that Croatia provides, by international standards, one of the most generous sick leave and maternity compensation packages, which, according to some, could make the system open to abuse.[16] This all indicates a need for monitoring mechanisms to oversee the correct application of compensation packages with special attention to the implementation of legal provisions to protect women at work.

83. A different set of barriers regarding women's right to health relates to shelters and counselling centres for victims of domestic violence, which lack consistent and adequate funding. Legal reforms are necessary to effectively protect women from domestic violence, and to address remaining gaps in the implementation of the hate crime provisions of the Criminal Code, involving violence against lesbian, gay, bisexual and transgender people. The Special Rapporteur was informed about alleged violent and abusive acts by law enforcement officials, including insults, physical aggression, violations of victims' rights and rejection of complaints on insufficient grounds.

84. During his visit, the Special Rapporteur was able to observe at first hand a matter about which the Committee on the Elimination of Discrimination has consistently cautioned, regarding church-related organizations which appear to adversely influence policies concerning women's rights, thereby impeding the full implementation of human rights international treaties. Sexual and reproductive health services that are most needed by women, in particular young women, include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion and prevention and treatment of sexually transmitted

[16] See European Observatory on Health Systems and Policies, "Croatia: Health system review", p. 52.

infections and HIV/AIDS (see E/CN.9/2014/4 and Corr.1, paras. 68-77). Poverty, low education levels, insufficient access to health services, gender discrimination and a lack of empowerment constitute barriers for women with regard to making the best informed choices about their sexual and reproductive health and the health of their children, giving rise to poorer health outcomes and higher risks (see A/HRC/27/31, para. 74).

85. Sexual and reproductive health rights are human rights. Retrogressive measures preventing access to safe abortion and contraceptives and hindering access to age-appropriate comprehensive sexuality education may amount to human rights violations (see Economic and Social Council, general comments No. 14 on the right to the highest attainable standard of health, para. 48, and No. 22 (2016) on the right to sexual and reproductive health, para. 38). Sexual and reproductive health rights also indicate that primacy should be given to women's and children's rights and not to the family unit. In this respect, the Special Rapporteur is concerned about the potential redefinition by the Constitutional Court of marriage as the union between a man and a woman, should this hinder proper access to sexual and reproductive health rights on the basis of marital status.

86. The Special Rapporteur noted strong opposition among policymakers and within society at large towards well-established standards, instruments and mechanisms for the promotion and protection of women's sexual and reproductive health rights. He urges all stakeholders to support policies based on universal human rights principles, including those concerning sexual and reproductive health, and to reject what could be seen as conspiracy theories, which promote patriarchal gender stereotypes and undermine the role of women and girls in society. These theories are detrimental to the enjoyment of all rights, including the right to health, in particular of women and children. The Croatian authorities must ensure full adherence to universal and regional human rights principles and standards which, if applied in a consistent manner, constitute the basis for the realization of the right to health and other rights.

V. Right to health of key population groups

A. Children

87. While there have been advances in some health indicators, notably child mortality, Croatia still faces challenges regarding children's health, including easy access to alcohol and tobacco, linked to a lack of compliance with relevant law.[87]

88. Additional well-documented challenges include the lack of, and difficulty of access to, certain health-care experts, including paediatricians, health-care specialists at schools and universities, speech therapists, psychologists, occupational therapists, nurses and social workers. For example, many paediatricians are close to retirement age, although enrolment into paediatric training programmes is decreasing. This is leading to an increased number of infant patients per primary care team, leaving insufficient quality time for preventive care, including for the screening and identification of children with developmental difficulties, which appear to be increasing.

89. A common concern for the ombudspersons for children and persons with disabilities relates to children's mental health and particularly that of children with autism. The Croatian system seems to lack adequate capacity, with insufficient health-care personnel and facilities. A large number of children with mild to moderate autism are not identified until they reach school age, indicating the need for a coordinated package of early childhood interventions in or close to the areas where they live.

90. While an important step was taken by including early childhood interventions as a service in the Social Welfare Act in 2011, the State has yet to create the conditions for the implementation of such provision. According to official data, in 2013 there were 4,800

[87] Croatian Ombudsperson for Children 2014. Report on her work, March 2015, p. 17. Available from http://www.dijete.hr/en.html.

children who required such services, but only 641 (13 per cent) had access. Early childhood interventions are provided through a small number of facilities located in or around the capital and at a high cost for average parents. Only one institution in Croatia specializes in early childhood interventions, but this is understaffed and therapy is often discontinued after the age of 3.

91. A more systematic approach, which integrates health, education and social services, is needed for the early screening and detection of developmental challenges in young children at the primary health-care level. This requires the introduction of appropriate, standardized, scientifically reliable and valid instruments and a family-centred approach to monitoring child development, with the family as an active partner. Primary health-care workers should have access to professional educational development and protocols and guidelines should be developed for the cross-sectoral collaboration of health, education and social services in the assessment, diagnostic and early intervention services for children with developmental challenges and risks.

92. With regard to breastfeeding, relevant advances include the adoption of the national programme for protecting and supporting breastfeeding in May 2015 and designation of all 31 maternity hospitals as "baby-friendly". However, while the rate of early initiation of breastfeeding is high (80 per cent), its duration has not significantly increased, in part owing to lack of awareness of the benefits of exclusive breastfeeding and lack of adequate support services for women.

93. The Special Rapporteur gathered information on the strong support of most paediatricians in Croatia for introducing solids to babies as early as 17 weeks. He also learned of the counterproductive influence of companies that market breast milk substitutes, which is evident in their regular sponsorship of conferences for paediatricians and nurses, which is not perceived as constituting a conflict of interest in the country.

94. Breastfeeding is a human right that should be protected and promoted. Women should be supported in their choice and ability to breastfeed their infants optimally, with adequate information and services and without being condemned or judged if they do not want to or are unable to. However, breast milk substitute marketing negatively affects women's choices and can prevent both babies and mothers from enjoying the many health benefits of breastfeeding. Croatia should fully align with the International Code of Marketing of Breast-milk Substitutes, including the sanctioning of Code violators and subsequent relevant World Health Assembly resolutions.

95. Additional challenges in the area include the monitoring of breastfeeding practices, which is currently insufficient and not uniform throughout the country; the feeding of children whose mothers are HIV positive, on which guidelines are yet to be developed; and infant feeding in emergency situations, on which there is still a lack of policy measures to protect breastfeeding.

B. People on the move

96. Croatia is still perceived as a transit country, with some 70 per cent of asylum seekers absconding from the country to continue their onward movement. Between September 2015 and March 2016, a total of 658,068 refugees and migrants transited Croatia during the refugee emergency response. Subsequent to the closure of the "Western Balkans route" in March 2016, there was an increase in the number of asylum seekers in Croatia, including individuals transferred to Croatia under the Dublin II Regulation. By the end of September 2016, the Government had recorded 1,584 asylum seekers, which, compared with the annual statistics for 2015 (211), indicates a considerable increase. Reception capacity is 700 persons, with centres in Porin, Zagreb and Kutina, about 80 km from Zagreb.

97. Croatia is a signatory to the main international and regional instruments protecting the rights of refugees and stateless persons, notably, the Act on International and Temporary Protection 2015, adopted in July of that year to harmonize national asylum

legislation with the European Union acquis communautaire regulating protection of third country nationals.

98. Asylum seekers in Croatia are entitled to health care through the Mental Health Insurance Act and Law on Mandatory Health Insurance and Health Care for Foreigners in the Republic of Croatia. However, with the most recent amendments to the Act on International and Temporary Protection, health care in Croatia was restricted to emergency care and the most essential treatment of illnesses and serious mental conditions, thereby restricting effective access to health care. This has particularly affected children and pregnant women who are both asylum seekers and migrants. An additional barrier is language, as free interpreting services are not provided by the Government and most asylum seekers are unable to pay for such assistance.

99. As ascertained by the Special Rapporteur, many children arriving in Croatia have not been vaccinated against preventable diseases. Urgent efforts are needed to vaccinate all children without relevant health records who arrive or are born in Croatia and to provide all pregnant women with regular medical care, irrespective of their nationality or legal status. Likewise, medical check-ups upon arrival should be immediately reinstated.

100. The Special Rapporteur observed that, since September 2016, the provision of services had improved at the Porin Reception Centre, with the regular attendance of a general practitioner and the support of the non-governmental organization Médecins du Monde. However, he also noted the need for the national authorities to promptly undertake the work currently carried out by that organization in order to ensure continuity, ownership and compliance with international obligations. Similarly, the regular presence of a general practitioner in Kutina should be ensured, as at the time of the visit this was still lacking.

101. The Special Rapporteur was informed about the outstanding work done by humanitarian organizations vis-à-vis the refugee emergency response. These organizations should have access to all migrants in need irrespective of their legal status. Migrants should always be treated in a way that respects their dignity and upholds their fundamental rights. Notwithstanding the valuable work of humanitarian organizations, the State remains the main duty-bearer responsible for ensuring the protection and the full realization of the rights of people on the move.

C. Roma

102. Croatia has invested relevant efforts in improving the inclusion of Roma, including the National Roma Inclusion Strategy 2013-2020 and the related Action Plans. A significant aspect is the introduction of "health mediators" recruited from Roma communities to provide direct support in accessing health-care services. The Special Rapporteur noted the Government's awareness of the ongoing challenging situation faced by Roma in Croatia, who remain the most marginalized minority, and the will to address challenges.

103. Ongoing and upcoming measures specifically targeting the Roma population are welcomed, but there is a need to further strengthen the existing framework.

104. Available data indicate that one fifth of Roma children in Croatia may not have access to health care and that infant mortality rates for Roma children, in particular mortality associated with sudden infant death syndrome and respiratory diseases, are significantly above the national average.

105. Roma women face various constraints in access to health care, as a result of multiple discrimination and social exclusion based on ethnicity affiliation, gender and social status. Available data indicate that 21 per cent of Roma women have never had any health insurance, with the exception of pregnant women who access public support for expectant mothers.

106. The main barriers for Roma in accessing health care relate to challenges in obtaining identity documents. By 2016, about 2,800 Roma were still without permanent or temporary

residence[41] and at risk of statelessness. While Roma in Croatia are insured, a critical gap relates to the fact that they pay for their own insurance.

107. In his visit to a Roma settlement, the Special Rapporteur noted that environmental conditions may be a threat to their health and aggravated by climate and other factors, including the inadequate collection of waste by the relevant authorities. He also observed that their diet is nutritionally deficient and is particularly affecting children, with a direct impact on school dropout rates. Deficient diets also largely contribute to aggravation of chronic diseases in adulthood.

D. People who use drugs

108. In 2015, health-care facilities treated 7,533 persons for psychoactive substance dependence, of whom nearly 1 in 10 was under 20. Most of the patients treated were in the 30-39 age group and opiate dependence was the predominant type.[42]

109. While the Ministry of Health is the body primarily responsible for treatment for drug dependence, certain treatments, including programmes for young drug users, rehabilitation and resocialization of drug dependence come under the Ministry of Social Policy. While the Ministry of Justice is responsible for treatment for drug dependence in prisons and during probation, the Office for Combating Drug Abuse, county authorities and certain donors also participate in therapeutic communities.

110. The national strategy on combating drug abuse (2012-2017) includes a public health approach with the purpose of reducing both the demand for, and the supply of, drugs in society, protecting the health of individuals, families and communities. County committees for combating drug abuse composed of experts and members of local administrations were established in 2014 and 2015 to coordinate the implementation of the Strategy at the local level.

111. Accordingly, while some hospital-based inpatient treatment and therapeutic communities remain, drug treatment in Croatia is centred on the provision of outpatient care, through county services for the promotion of mental health and dependence prevention. Services include individual and group psychotherapy, prescription and continuation of opioid substitution therapy and other pharmacological treatments and testing and counselling on a wide range of issues, with a prevalence of medication-based treatments and harm-reduction programmes, including substitution therapies and syringe programmes.

112. In his visit to the Split Counselling Centre for the Prevention and Treatment of Addiction, the Special Rapporteur welcomed the interdisciplinary approach applied in the prevention and treatment of drug dependence and associated mental health conditions, with services provided on a voluntary basis. The approach paves the way for a positive outcome for therapeutic interventions.

113. In addition to these centres, outpatient drug treatment is provided by some associations, general practitioners and some outpatient units in general hospitals, with psychosocial treatment for enhancing interpersonal relationships and users' life situations that complement opioid substitution therapy and other treatments. Guidelines for the psychosocial treatment of drug users in the health-care, social and prison system were adopted in 2014 to standardize the delivery of such treatment.

[41] UNHCR data quoted in Amnesty International report on Croatia 2016-2017. Available from https://www.amnesty.org/en/countries/europe-and-central-asia/croatia/report-croatia/.

[42] Croatian Institute of Public Health, *Croatian Health Statistics Yearbook 2015*, p. 23.

VI. Conclusions and recommendations

114. **Croatia has made significant advances towards the progressive realization of the right to health. Despite a number of challenges, the State has striven to make its health-care system sustainable and accessible.**

115. **Measures have been taken to develop and strengthen primary and specialized health care, with the investment of innovative efforts in mental health reforms and interdisciplinary approaches to address drug use and dependence.**

116. **The right to health should be promoted and protected not only through access to health services, supplies and facilities, which should be available, affordable, appropriate and of good quality. The right to health is also realized through the enjoyment of the underlying and social determinants of health, and it requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving interventions but also on broader socioeconomic, cultural and environmental factors.**

117. **Health policies and programmes in Croatia should be guided by a rights-based approach with a strong emphasis on the principles of equality and non-discrimination, transparency, participation and accountability. Issues related to the right to health are intersectoral and should be addressed by means of horizontal approaches that promote the effective use of primary care and incorporate the concerted efforts of all stakeholders.**

118. **The Special Rapporteur recommends that the State:**

(a) **Further advance the right to health with rights-based policies, in line with the 2030 Agenda for Sustainable Development, avoiding any retrogressive measures and paying particular attention to groups in the most vulnerable situations, including women, children, people on the move, minorities, persons with intellectual, cognitive and psychosocial disabilities and older persons;**

(b) **Continue to promote and strengthen primary health care, seeking an optimal balance between general practitioners and specialists, while providing specialist outpatient care, ensuring coordination between specialists and general practitioners and improving the capacities and competencies of general practitioners and their teams;**

(c) **Strengthen primary level capacity for early intervention services for children, with a family-centred and interdisciplinary approach and clear guidelines for cross-sectoral collaboration among the health, education and social services sectors;**

(d) **Fully align with the International Code of Marketing of Breast-milk Substitutes by further developing mechanisms to monitor breastfeeding practices and produce guidelines and protocols for children whose mothers are HIV positive and for infant feeding in emergency situations;**

(e) **Produce official reliable statistics on the remaining challenges for the health system, including long waiting lists; access to maternity hospitals, information on medically assisted reproduction; contraceptive prevalence; unmet needs for family planning, and the prevalence of conscience-based refusals to abortion in order to assist in the development of practical measures to address these issues;**

(f) **Give priority to women's and children's rights in the area of sexual and reproductive health rights, with appropriate access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion;**

(g) **Develop comprehensive sexuality education in schools, build the capacities of teachers in this area, and monitor programme performance;**

(h) **Ensure that informed consent is obtained by allocating adequate time to inform users about treatments, their effects and options on the basis of services that**

are sensitive to the rights of all users and through improved training of medical doctors and other health-care personnel in human rights and medical ethics;

(i) Invest resources, including European Union structural funds, ensuring a modern rights-compliant approach to mental health-care system throughout the country, with the aim of strengthening community-based outpatient services that can help stop excessive referrals to long-term care institutions;

(j) Cease directing funds/investments, either national or international, to reinforcing the inefficient system of segregated large psychiatric hospitals and residential institutions, and redirect them to the development of community-based services which focus on the needs and rights of the users and not on the needs of the existing service infrastructure;

(k) Replicate throughout the country the good practices of deinstitutionalization, with local plans in each county and the meaningful participation of relevant stakeholders;

(l) Immediately reinstate mandatory initial medical check-ups upon arrival in the country for people on the move, and build capacity to assume responsibility for the services provided by non-governmental organizations in reception centres, in close collaboration with the latter;

(m) Urgently develop measures to vaccinate all children without relevant health records that arrive or are born in Croatia and provide all pregnant women with regular medical care, irrespective of their nationality or legal status;

(n) In the context of the refugee emergency response, ensure access by humanitarian organizations to all migrants in need, irrespective of their legal status;

(o) Expand health-care insurance and services for Roma with outreach programmes for Roma children and mothers.

119. The Special Rapporteur recommends that all stakeholders in Croatia support policies based on universal human rights principles, including sexual and reproductive health rights, and reject patriarchal approaches and gender stereotypes detrimental to the enjoyment of all human rights, in particular the right to health of women and children.